Drug Reaction Alerts

Drug Reaction Alerts focuses primarily on serious, unlabeled reactions to new chemical entities. The citations are compiled monthly from International Pharmaceutical Abstracts, which covers over 800 pharmacy and health-related journals worldwide. An address for reprints (when available) follows the name of the corresponding author in each citation.

Pharmacists may use the FDA medical products reporting form that appears in the January 1 and July 1 issues for submitting reports of adverse drug reactions directly to FDA.

Drug Reaction Alerts appears in the first issue of each month; Journal References appears in the second issue.

Antiparkinson Drugs

Pseudopheochromocytoma in a patient with Parkinson's disease. Ann Pharmacother. 1996; 30:546. Duarte J (General Hospital of Segovia, Ctra de Avila s/n, 40002 Segovia, Spain), Sempere AP, Cabezas C et al. Case. (62-year-old woman with nine-year history of idiopathic Parkinson's disease; received levodopa 600–1000 mg/day for several years and selegiline 10 mg/day for one week after withdrawal of selegiline because of drug-induced nausea and vomiting, then received alprazolam for treatment of anxiety but did not improve, and then developed hypertensive crisis, diaphoresis, palpitations, and flushing; concommitant lorazepam, amitriptyline, and medazepam; abnormally high plasma concentrations of norepinephrine and epinephrine supported pheochromocytoma as primary diagnosis, but specific tests could not confirm)

Cardiac Drugs

Possible erythromelalgia-like syndrome associated with nifedipine in a patient with Raynaud's phenomenon. Ann Pharmacother. 1996; 30:484-6. Sunahara JF, Gora-Harper ML (University of Kentucky Hospital, 800 Rose Street, Lexington, KY 40536), Nash KS. Case. (24-year-old woman with Raynaud's phenomenon; received oral nifedipine 10 mg four times daily for four doses; one hour after fourth dose of nifedipine experienced acute erythema and burning sensation in feet and lower limbs, lightheadedness, and palpitations; withdrawal of nifedipine led over 24 hours to complete resolution of symptoms)

Drug Abuse

Cerebral edema after ingestion of MDMA (Ecstasy) and unrestricted intake of water. BMJ. 1996; 312:1359. Mathai SM, Davidson DC, Sills JA et al. (Alexandrou D, Alder Hey Children's Hospital, Liverpool L12 2AP, England). Cases. (two girls, ages 15 and 16 years; ingested unstated quantities of alcohol and 3,4-methylenedioxymethamphetamine [MDMA]; found semiconscious from cerebral edema about 18 and 21 hours, respectively, after ingestions;
severe restriction of fluid intake led over 24 hours to correction of serum osmolality and electrolyte disturbances, with 15-year-old girl recovering without sequelae and 16-year-old girl having some retrograde and anterograde memory loss)

Drug Interactions

Carbamazepine-lithium drug interaction. Ann Pharmacother. 1996; 30:547. Mar- cous AW (Value Health/HPI. Fernald Developmental Center, 200 Trapelo Road, Waltham, MA 02154). Case. 33-year-old woman with bipolar disorder, seizures, hypothyroidism, and mild mental retardation who was receiving lithium carbonate at unspecified dosage as maintenance therapy; received carba-mazepine at unspecified dosage as replacement for phenytoin to control seizures and also to control manic episodes; within 14 days of starting carba-mazepine therapy developed tiredness, tremors, stumbling, unsteadiness, and slumping in chairs, with carbamazepine concentration of 3.3 mg/mL [therapeutic range, 4-12 mg/mL], unbound carba-mazepine concentration of 0.9 mg/mL [0.5-4.0 mg/mL], and lithium concentration of 0.78 mM [0.6-1.2 mM]; concomitantly tiothiazidine and levo-thyroxine; withdrawal of carbamazepine led within 10-14 days to dramatic diminishing of symptoms, with minor unsteadiness and continued slumping in chairs.

Possible interaction involving phenytoin, dexametha-sone, and antineoplastic agents: a case report and review. Ann Pharmacother. 1996; 30:547. Thompson PA (Mercy Healthcare, San Di-go, CA 92103). Mosley CA. Case. (46-year-old man with hypertension, generalized seizure disorder, diabetes mellitus, and renal insufficiency after kidney transplantation who was receiving oral phenytoin 600 mg/day alternating with 500 mg/day as maintenance therapy, with phenytoin concentrations in therapeutic range: received oral tacrolimus 14 mg twice daily after renal-tissue biopsy showed evidence of rejection: tacrolimus, total phenytoin, and albumin concentrations were 10.8 ng/mL [low], 24.7 g/mL, and 3.3 g/dL [decreased from 3.8 g/dL], respectively, after 21 days of tacrolimus therapy: concomitant azathioprine, bumet-anide, digoxin, diltiazem, heparin, insulin, and pred-nisone: tacrolimus dosage was increased to 16 mg twice daily, and one month later man experienced episode of syncope: withdrawal of phenytoin for eight days and increase in tacrolimus dosage to 17 mg twice daily led to decrease in total phenytoin concentration from 36.2 µg/mL to 22.2 µg/mL; reinstitution of phenytoin at previous dosage, with albumin concentration of 23.6 g/dL and tacrolimus dosage of 16 mg twice daily, did not lead to recurrence of syncope)

Folk Medicine

Tetracyclines

Garlic burns mimicking herpes zoster. Lancet. 1996; 347:1195. Farrell AM (Department of Dermatology, Chelsea and Westminster Hospital, London SW10 9NH, England). Staughton RC. Case. (29-year-old woman: applied compressed of crushed garlic wrapped in cotton wool to right side of chest and upper abdomen for 18 hours; developed painful, erythematous, blistering rash that was initially diagnosed as herpes zoster; swabs of skin lesions were negative for bacteria and viruses; skin lesions healed with scarring)

Platelet Aggregation Inhibitors

Aplastic anemia with ticlopidine therapy in two Chinese patients. Ann Pharmacother. 1996; 30:547. Dunn P (Division of Hematology-Oncology, Department of Internal Medicine, Chang Gung Female Hospital, 199 Tung Hwa North Road, Taipei, Taiwan, Republic of China). Cases. (two women, ages 66 and 67 years, one with recurrent cerebral infarct and other with hypertension, angina pectoris, and intermittent claudication: received ticlopidine 500 mg/day for six weeks; developed severe aplastic anemia, with hemoglobin concentrations of 11.6 and 12.5 g/dL, white blood cell counts of 700/mm³ and 500/mm³, and platelet counts of 7,900/mm³ and 500/mm³, respectively; concomitant propranolol, diltiazem, and isosorbide dintrate in 67-year-old woman: withdrawal of ticlopidine and therapy with cefamandole, gentamicin, and fligrastim in 66-year-old woman and with ceftriaxone, amikacin sulfate, and fligrastim in other woman led in three to four weeks to complete recovery)

Tetracyclines

Serum sickness-like reaction associated with minocycline therapy in adolescents. Ann Pharmacother. 1996; 30:481-3. Harel I (Department of Pediatrics C, Children's Medical Center of Israel, Petah Tiqva 49 202, Israel). Amir I, Livni E et al. Cases. (three girls and two boys, ages 12-16 years, with acne or pneumonia; received minocycline 100-200 mg/day for 10-30 days; developed rash and arthralgias or swelling of joints; results of macr- ophage migration inhibitory factor assay and mast-cell degranulation test were positive in four of five patients; withdrawal of minocycline and therapy with thiprophene, hydroxyzeno with or without prednisone, or methyldrostan led within a few days; weeks to resolution of signs and symptoms of serum sickness-like reaction)

Tetracycline-induced oral mucosal ulcerations. Ann Pharmacother. 1996; 30:548. Nordt SP (San Diego Regional Poison Center, University of California, San Diego Medical Center, San Diego, CA 92103). Case. (48-year-old man with pharyngitis: gargled and swallowed oral solution of tetracycline 250 mg every six hours, in accordance with physician's instructions; after one day of tetracycline therapy developed oral mucosal ulcerations and pain, which worsened over next three days; withdrawal of tetracycline led within two to three days to abatement of oral ulcers and pain)

Toxicity

Dependency on progesterone in woman with self-diagnosed prenatal syphilis. Lancet. 1996; 347:1182. Keefe DL (Division of Reproductive Endocrinology, Department of Obstetrics and Gynecology, Yale University School of Medicine. New Haven, CT 06520-8063). Sarrel P. Case. (43-year-old woman with anxiety disorder who diagnosed premenstrual syndrome; received progesterone up to 6400 mg/day for three years in suppositories, implants, and injections; developed constipation, head-
ache, nausea, weakness in leg, and low-grade fever, with serum progesterone concentration of >397.5 nM; tapering of progesterone intake led in three days to serum progesterone concentration of 246.9 nM, return of temperature to normal, subsiding of headache, abatement of nausea, and resolution of neuropathy and weakness in leg; woman demanded reinstitution of high-dose progesterone therapy when she developed increased anxiety, restlessness, insomnia, and agitation and left hospital against medical advice.

**Book Review**

**Strong Shadows: Scenes from an Inner City AIDS Clinic**


Perhaps no malady—at least in modern history—is associated with as much consternation as AIDS. Fifteen years have passed since initial observation of the acquired immunodeficiency syndrome or complex, but our society is still struggling with how to deal with this disease. Often forgotten—or overshadowed by international scientific meetings, clinical case conferences, public policy forums, the $1.4-billion NIH budget for AIDS, Oscar-winning movies, and celebrities with AIDS—are the ravaged people infected with the human immunodeficiency virus (HIV) who must cope daily with a terminal disease. Sadly, the still-prevalent stigma of AIDS seems more threatening at times than the infection itself.

“I know I have a bad disease, but I’m still a human being,” a patient with AIDS told Abigail Zuger, author of Strong Shadows: Scenes from an Inner City AIDS Clinic. An attending physician at the Spellman Center for HIV-Related Diseases in New York City, Zuger offers a cogent, insightful documentary about eight people with AIDS trying to obtain medical, social, and supportive care from the clinic at a large urban hospital with limited resources.

The cynosure of this book is not the antiretroviral “cocktail du jour” or the hottest research protocol, but indigent patients dying from a dreadful disease. Many Americans view these people as the dregs of society—illicit drug users, prostitutes, the poverty-stricken, many of whom are second- and third-generation welfare recipients. Why should society care about these social misfits?

Without promoting a social agenda, Zuger compassionately reveals the human character, emotion, and soul of the HIV-infected urban poor. In describing her patients’ difficulties—therapeutic dilemmas, family problems, bureaucratic intransigence, end-